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Primary Trauma of Female Partners in a Military Sample: Individual Symptoms and Relationship Satisfaction

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Abstract

Research traditionally has focused on the development of symptoms in those who experienced war-trauma directly but overlooked the impact of trauma in the partners of soldiers. The current study reports data from 45 couples where the male partners were Army soldiers who recently returned from deployments to Iraq (Operation Iraqi Freedom) or Afghanistan (Operation Enduring Freedom). Results from this study indicated that female partner primary trauma, particularly trauma related to PTSD re-experiencing and arousal symptoms, has an influence on levels of relationship satisfaction, both for female partners and soldiers.

Key Words: female trauma, PTSD, military couples, Operation Iraqi Freedom/ Operation Enduring Freedom

Impact of Trauma on Military Samples

Events of war have long been considered traumatic, and research has found that those exposed to war may develop posttraumatic stress disorder (PTSD) or psychological difficulties (American Psychiatric Association [APA], 2000). Further, this trauma extends beyond the experiences of the soldiers themselves, individually influencing their partners through secondary traumatization (Maloney, 1988; Solomon et al., 1992) and their couple relationship (Carroll, Rueger, Foy, & Donahoe, 1985; Nelson Goff, Crow, Reisbig, & Hamilton, 2007; Nelson Goff & Smith, 2005; Riggs, Byrne, Weathers, & Litz, 1998).

At the end of 2007, there were a total of 222,300 deployments to *Operations Iraqi Freedom* (*OIF*) and *Enduring Freedom* (*OEF*) alone (Department of Defense, 2008). Recent research has indicated the instance of increased PTSD and other symptoms in returning OIF/OEF soldiers (Hoge, Castro, Messer, McGurk, Cotting, & Koffman, 2004), and that soldiers' trauma symptoms negatively affect relationship satisfaction in OIF/OEF soldiers and spouses (Nelson Goff et al., 2007).

Family members may be left to assume responsibilities employed by the soldier prior to his/her deployment (Armstrong, Best, & Domenici, 2006), and spouses may be charged with responsibility to ensure that all remains well at home, both during the deployment and re-integration periods. Consequently, the wellbeing of the spouse becomes paramount, both individually and relationally. However, research has failed to explore previous trauma experiences and symptoms of spouses/partners of soldiers (i.e., most trauma research focuses exclusively on soldiers or other primary trauma survivors). It was our intention to address this area, not to ignore the impact of soldiers' primary trauma, but to identify additional trauma variables that might be overlooked by focusing exclusively on those primary trauma survivors. It

was from our larger research study, including qualitative interviews with both partners, where we became aware of the extensive history of trauma exposure in the female partners of the soldiers. For this reason, we sought to further explore the trauma history in the female partners and how it impacted their couple relationship.

Given the tendency for traumatic stress to negatively influence relationship satisfaction (Dirkzwager, Bramsen, Adèr, & van der Ploeg, 2005; Nelson & Wampler, 2000; Nelson Goff et al., 2007; Riggs et al., 1998; Whiffen & Oliver, 2004), it was expected that the primary trauma experiences of a sample of female partners of OIF/OEF soldiers would likewise negatively impact relationship satisfaction for both themselves and the soldiers. The primary hypothesis for the current study was:

(1) Greater trauma history and individual trauma symptoms of female partners will predict lower relationship satisfaction for themselves and male partners.

Based on the preliminary analyses for Hypothesis 1 and the literature that indicates avoidance symptoms most affect relationship satisfaction (Cook, Riggs, Thompson, Coyne, & Sheikh, 2004; Galovski & Lyons, 2004; Riggs et al., 1998), the supplemental hypotheses for the current study were:

(2) Greater individual trauma symptoms of female partners, specifically avoidance symptoms, will predict their lower relationship satisfaction.

(3) Greater individual trauma symptoms of female partners, specifically avoidance symptoms, will predict lower relationship satisfaction in the soldiers.

Methods

Procedure

The research described here is part of a larger study of military couples extending beyond their OIF/OEF deployment experiences, including data from quantitative surveys and individual

qualitative interviews with each partner. Couples were recruited in two small cities in the Midwest that neighbor Army posts in close proximity to the university where the research was conducted. Data collection began 8/25/04 and concluded 6/20/05. Out of 56 total couples who initially agreed to complete the study protocol, 11 cancelled or did not show for their scheduled appointment, resulting in a final sample size of 45 couples with complete data (response rate = 80.36%). (For more information on the research procedure, please contact the corresponding author.)

Research Participants

The total sample included 45 male soldiers and 45 female partners. Although female soldiers were not excluded from the sample, no female soldiers elected to participate. Of the soldiers, 95.6% (n = 43) served in OIF, and 69% (n = 31) were at the enlisted rank. In addition, 91.1% (n = 41) were recruited from the Ft. Riley area and 9.9% (n = 4) were recruited from the Ft. Leavenworth area. The average length of deployment was 10.03 months (SD = 3.98), with an average of 5.10 months (SD = 3.39) since the time the soldiers redeployed home and when they completed the research study.

Soldiers reported an average age of 31.18 (SD = 6.90), while female partners reported an average age of 29.36 (SD = 6.27). The majority of soldiers (82.2%; n = 37) and female partners (77.8%; n = 35) reported being of European American decent. Employment status indicated that 95.6% (n = 43) of soldiers worked full-time in the military, while 51.1% (n = 23) of female partners worked full- or part-time. The median annual income range for participants was $30,000-39,999. The participants indicated that 95.6% (n = 43) were currently married. The average relationship length was 5.31 years (SD = 5.47)

Measurement Instruments

Traumatic Events Questionnaire (TEQ). The TEQ (Vrana & Lauterbach, 1994) was used to confirm the history of trauma and types of trauma exposure reported by the participants. The purpose of the scale is to determine the experience of each participant with various types of trauma that have the potential to produce symptoms of post-traumatic stress (Lauterbach & Vrana, 1996). In the current study, affirmative answers on the 17 TEQ items were tallied to provide a "TEQ Total" score, ranging from 0 to 17, with higher scores indicating more types of traumatic events experienced.

Purdue Post-Traumatic Stress Disorder Scale-Revised (PPTSD-R). The PPTSD-R (Lauterbach & Vrana, 1996) consists of 17 items that correspond to each *Diagnostic and Statistical Manual for Mental Disorders, 4th Edition*, diagnostic criteria for PTSD (APA, 1994), with three subscales that reflect the three general symptom categories of Re-experiencing (4 items), Avoidance (7 items), and Arousal (6 items). The PPTSD-R items are scored from 1 ("Not at all") to 5 ("Often"), with continuous total scores ranging from 17-85; higher scores indicate greater PTSD symptoms. The measure, which does not provide a diagnosis or cut-off score, asks participants to indicate how often each reaction occurred during the previous month. For the current study, Cronbach alpha estimates for the subscales were adequate for Re-experiencing (soldiers = .87; female partners = .89), Avoidance (soldiers = .73; female partners = .86), Arousal (soldiers = .87; female partners = .93), and Total (soldiers = .92; female partners = .95).

Trauma Symptom Checklist-40 (TSC-40). The TSC-40 (Briere, 1996; Briere & Runtz, n.d.) is a research measure that evaluates symptomatology in adults who have experienced previous traumatic experiences. The TSC-40 is a 40-item self-report instrument that ranges from 0 ("Never") to 3 ("Often"), with total continuous scores ranging from 0-120. As with the PPTSD-R, higher scores indicate greater trauma symptoms. The measure, which does not

provide a diagnosis or cut-off score, asks participants to indicate how often they have experienced symptoms in the last two months (e.g., headaches, insomnia, flashbacks, sexual problems) that may result from previous childhood or adult traumatic experiences. The TSC-40, which has been used with a variety of trauma survivors (c.f., Briere & Runtz, n.d., for a list of references using the TSC-40), was included in the current study because of the additional symptom subscales it provides and it is a measure of general trauma symptoms beyond PTSD. In the current study, Cronbach alpha estimates for the Total scale estimates ranged from .92 for soldiers and .94 for female partners. The correlation between the PPTSD-R and the TSC-40 in the current study was .82.

Dyadic Adjustment Scale (DAS). Relationship satisfaction/quality was assessed with the DAS (Spanier, 1976), which is a 32-item, variable-Likert measure assessing the quality of the relationship as perceived by both partners. Total scores range from 0-151, with higher scores indicating greater relationship satisfaction. Cronbach alpha estimates for the DAS were .93 for both soldiers and female partners.

Results

Statistical Procedures

A series of linear multiple regression models, using the Statistical Package for the Social Sciences (SPSS, 2004) were completed to determine the independent variable(s) (trauma history and trauma symptom scores, as measured by the TSC-40, PPTSD-R, and TEQ scores for the female partners of soldiers) that best predicted the dependent variable (relationship satisfaction, as measured by the DAS scores for soldiers and their female partners). Based on the initial multiple regression analysis, additional multiple regression analyses were conducted with the PPTSD-R subscale results. Stepwise (statistical), multiple regression using backward deletion

was used in the analyses resulting in the elimination of the least predictive variables from each model. Pre-analysis screening for multivariate outliers using Mahalanobis distance (Mertler & Vannatta, 2002) led to the deletion of one couple's data, leaving 44 couples' data available for the first two analyses (Hypothesis 1), and 43 couples' data for the subscale analyses (Hypotheses 2 and 3). A summary of the descriptive statistics and correlation results is presented in Table 1.

Predicting Current Relationship Satisfaction Based on Trauma History and Trauma Symptoms

To test Hypothesis 1, two regression analyses were conducted to examine the predictive contributions of the female partners' trauma history and trauma symptoms, as measured by the TEQ, TSC-40, and PPTSD-R, on current relationship satisfaction (DAS scores) for both the female partners (first regression analysis) and the soldiers (second regression analysis). The most significant predictor of relationship satisfaction was the PPTSD-R scale, both for the female partners, $R^2 = 0.21$, *Adj* $R^2 = 0.19$; $F\ (1,42) = 11.06$, $p < .01$, and for the soldiers, $R^2 = 0.33$, *Adj* $R^2 = 0.09$; $F\ (1,42) = 5.20$, $p < .05$. Thus, Hypothesis 1 was partially supported, as the trauma symptoms (PPTSD-R) of female partners significantly predicted relationship satisfaction scores for both themselves and the soldiers. Results of these analyses are presented in Table 2.

Current Relationship Satisfaction Based on PPTSD-R Subscales

Because the PPTSD-R scale significantly predicted relationship satisfaction in the overall regression analyses, only the PPTSD-R subscales were included in the analyses for Hypotheses 2 and 3. To test Hypotheses 2 and 3, the predictive value of the PPTSD-R subscale scores (Arousal, Avoidance, and Re-experiencing) on the soldiers' and the partners' current relationship satisfaction was examined through multiple regression analyses. Separate regression analyses were conducted for each hypothesis, which are presented in Table 3.

Female partners' individual symptoms predicting their own relationship satisfaction. In testing Hypothesis 2, when female partners' PPTSD-R subscales (Arousal, Avoidance, and Re-experiencing) were entered as independent variables, female partners' Re-experiencing scores significantly predicted their relationship satisfaction (DAS) scores, $R^2 = 0.15$, $Adj\ R^2 = 0.13$; $F(1,41) = 7.43$, $p < .01$. As such, Hypothesis 2 was not supported, as the Avoidance subscale score did not significantly predict the female partners' relationship satisfaction scores. In the final analysis, the female partners Re-experiencing subscale score accounted for 13% of the variance in their relationship satisfaction scores.

Female partners' individual symptoms predicting soldiers' relationship satisfaction. In testing Hypothesis 3, when female partners PPTSD-R subscales (Arousal, Avoidance, and Re-experiencing) were entered as independent variables, Arousal scores significantly predicted the soldiers' relationship satisfaction (DAS) scores, $R^2 = 0.15$, $Adj\ R^2 = 0.13$; $F(1,41) = 7.04$, $p < .05$. As such, Hypothesis 3 also was not supported, as the Avoidance subscale scores did not significantly predict soldiers' relationship satisfaction scores. The results indicated that the female partners' Arousal subscale scores accounted for 13% of the variance in the soldiers' relationship satisfaction scores.

Discussion

Although research has been conducted on the influence of primary trauma on soldiers, little research has addressed the influence of trauma exposure and traumatic stress symptoms in the spouses/partners of soldiers, specifically, the effects of the spouses'/partners' primary trauma on their intimate relationships in recent military couples. Results from the current study indicate that female primary trauma and PTSD symptoms negatively affected relationship satisfaction, for both female partners and soldiers.

Hypothesis 1 was partially supported, as trauma symptom scores in female partners predicted lower satisfaction for themselves and the soldiers. In order to further understand these results and based on previous research results (Cook et al., 2004; Galovski & Lyons, 2004; Riggs et al., 1998), it was theorized that the avoidance symptoms of the female partners in the current study would most significantly impact relational satisfaction, both for the partners and the soldiers. Surprisingly, the results indicated that female partners' avoidance symptoms did not significantly predict lower relationship satisfaction; rather, female partners' re-experiencing symptoms were found to most significantly predict their own levels of relationship satisfaction, and female partners' arousal symptoms were most indicative of low levels of relationship satisfaction for soldiers.

There are several possible explanations that shed light on the results of the current study. Perhaps female partners of soldiers are reminded of their own traumatic experiences as they watch the soldiers struggle upon return from war and listen to stories of their experiences in combat. This "re-experiencing" of traumatic events may lead female partners to believe the relationship is an emotionally unsafe place, thereby decreasing the level of satisfaction experienced. Other reasons for the results of the current study could be due to the tendency for female trauma victims to report re-experiencing symptoms more often than other trauma symptoms (Breslau, Chilcoat, Kessler, Peterson, & Lucia, 1999; Zlotnick, Zimmerman, Wolfsdorf, & Mattia, 2001). Perhaps female partners in the current study were more sensitive to their re-experiencing symptoms, including the possible ways these symptoms negatively influenced their levels of relationship satisfaction.

Soldiers may be most attuned to their partners' level of sensitivity or "arousal" in the couple relationship. If female partners are emotionally reactive due to their own trauma

symptoms (i.e., re-experiencing), it may lead soldiers to feel the relationship is not as neutral or safe as they had hoped in their desire for a reprieve from war. Indeed, soldiers may be used to being on the "offense" (Armstrong et al., 2006, p. 183) and alert to the actions of those around them, ready to respond. Consequently, the emotional reactivity of their spouse may feel like an attack that needs to be countered. Further, anger appears to be a prevalent emotion experienced by soldiers during combat (Reyes & Hicklin, 2005), which could make them more reactive to the emotional arousal of their spouse. As such, female partners' level of arousal, due to their re-experiencing symptoms, could negatively influence soldiers' level of relational satisfaction.

Although there are resources available to spouses addressing ways to effectively deal with the soldier's absence and the subsequent increase in responsibilities (e.g. Operation Ready, 2002; *Spouse's handbook*, 2003), these resources either fail to or minimally emphasize the importance of personal emotional awareness or the possible need to seek intervention for psychological concerns. Indeed, spouses/partners are strongly encouraged to understand their soldier's emotional concerns (National Center for PTSD, 2005), while the same emphasis is not placed on understanding their own. As such, in a whirlwind of constant demands ranging from physical health care, financial security, home safety, and possible relocations, it may be easy for overwhelmed caretakers to overlook their own needs. Consequently, partners may benefit from resources and services, including psychotherapy, that more specifically address their emotional functioning and the influence that their own primary trauma experiences have in individual and relationship functioning.

The results described here may be particularly important to recognize clinically, because they can provide a guide for therapists in assessment and interventions with military personnel and their partners. For example, systemic therapies often are viewed as "adjunct" to other

individual trauma treatments (e.g., cognitive behavioral therapy, exposure therapy; Riggs, 2000); however, trauma-related issues need to be evaluated and understood within a trauma framework (Johnson, 2002; Nelson Goff & Smith, 2005).

In sum, the results of the current study indicate the importance of awareness regarding female partner primary trauma given its influence on relationship satisfaction within military couples. The emotional condition of military families can no longer be considered solely within the realm of soldier trauma or secondary traumatization, but instead include consideration of the influence of primary traumatic experiences and resulting symptoms in partners.

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Table 1

Descriptive Statistics and Correlations Between Key Study Variables

	M	SD	Correlation with Soldier DAS	Correlation with Partner DAS
Female Partner TEQ	13.00	3.12	-.26	-.28
Female Partner TSC-40	79.00	27.85	-.35*	-.44**
Female Partner PPTSD-R	34.77	16.98	-.43**	-.48***
Female Partner Re-experiencing	9.06	4.71	-.36*	-.45**
Female Partner Avoidance	13.39	6.40	-.37*	-.43**
Female Partner Arousal	12.32	7.30	-.44**	-.44**
Soldier DAS	116.42	17.20	—	0.66***
Female Partner DAS	113.56	18.74	0.66***	—

Note: $n = 45$; * $p < .05$. ** $p < .01$. *** $p < .001$, two-tailed.

Table 2

Backward Multiple Regression Analyses Testing Hypothesis 1

	Female Partners' Trauma → Female Partners' DAS			*Female Partners' Trauma → Soldiers' DAS*		
Measures	B	*SE B*	β	B	*SE B*	β
Step 1	R = 0.48, *Adj* R^2 = 0.17, ΔR^2 = 0.23, F (3, 40) = 4.01*****			R = 0.34, *Adj* R^2 = 0.05, ΔR^2 = 0.12, F (3, 40) = 1.76		
TEQ	0.90	1.21	0.15	-0.06	1.12	-0.01
PPTSD-R	-0.45	0.26	-0.38	-0.24	0.24	-0.24
TSC-40	-0.23	0.23	-0.24	-0.10	0.21	-0.12
Step 2	R = 0.47, *Adj* R^2 = 0.18, ΔR^2 = -0.01, F (2, 41) = 5.80******			R = 0.34, *Adj* R^2 = 0.07, ΔR^2 = 0.00, F (2, 41) = 2.71		
PPTSD-R	0.39	0.25	-0.33	-0.24	0.23	-0.24
TSC-40	-0.16	0.21	-0.17	-0.10	0.19	-0.12
Step 3	R = 0.46, *Adj* R^2 = 0.19, ΔR^2 = -0.01, F (1, 42) = 11.06******			R = 0.33, *Adj* R^2 = 0.09, ΔR^2 = -0.01, F (1, 42) = 5.20*		
PPTSD-R	-0.54	0.16	-0.46**	-0.34	0.15	-0.33*

Note: n = 44; * p < .05. ** p < .01. *** p < .001.

Table 3

Backward Multiple Regression Analyses Testing Hypotheses 2 and 3

PPTSD-R Subscales	B	*SE B*	β
Hypothesis 2			
Step 1	R = 0.43, *Adj* R^2 = 0.12, ΔR^2 = 0.18, F (3, 39) = 2.87*		
Reexperiencing	-1.01	0.82	-0.26
Avoidance	-0.06	0.94	-0.02
Arousal	-0.48	0.72	-0.20
Step 2	R = 0.43, *Adj* R^2 = 0.14, ΔR^2 = 0.00, F (2, 40) = 4.42*		
Reexperiencing	-1.08	0.74	-0.26
Arousal	-0.52	0.45	-0.21
Step 3	R = 0.39, *Adj* R^2 = 0.13, ΔR^2 = -0.03, F (1, 41) = 7.43**		
Reexperiencing	-1.60	0.59	-0.39**
Hypothesis 3			
Step 1	R = 0.40, *Adj* R^2 = 0.10, ΔR^2 = 0.16, F (3, 39) = 2.48		
Reexperiencing	-0.52	0.79	-0.14
Avoidance	0.60	0.90	0.22
Arousal	-1.14	0.68	-0.49
Step 2	R = 0.39, *Adj* R^2 = 0.11, ΔR^2 = -0.01, F (2, 40) = 3.55*		
Avoidance	0.36	0.81	0.13
Arousal	-1.15	0.68	-0.49
Step 3	R = 0.38, *Adj* R^2 = 0.13, ΔR^2 = -0.00, F (1, 41) = 7.04*		
Arousal	-0.89	0.34	-0.38*

Note: n = 43; * p < .05. ** p < .01. *** p < .001.